TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Clint E. Hardin, D.C.

Respondent Name
Insurance Company of the State of Pennsylvania

MFDR Tracking Number
M4-15-3525-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a bill for an examination to determine the claimant's Impairment Rating, as referred by the claimant's treating doctor…

We billed a total of $2,150.00 for these services. *We have received no payment from your company.* Please issue prompt payment in the amount of **$2,150.00** to settle this claim."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs.

Coventry stands by the denial of the charges."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2014	Referral Doctor Examination (RTW/EMC)	$800.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code 4 – "THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING28 Texas Administrative Code §134.204 (k) states,

> The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE' …

Review of the submitted information finds that the examination in dispute was not requested by the Division or the insurance carrier. Further, the narrative and requestor's position statement indicate that the services in dispute is for an examination to determine if the injured employee had reached maximum medical improvement, and if so, determine the impairment rating. These examinations are addressed in28 Texas Administrative Code §134.204 (j). The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	August 21, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.